


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 09/30/2013
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505313 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 09/30/2013 |
| NAME OF PROVIDER OR SUPPLIER HALLMARK MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 32300 FIRST AVENUE SOUTH FEDERAL WAY, WA 98003 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| K 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 19192 On September 30, 2013 an unannounced complaint inspection was conducted at Hallmark Manor located at 32300 1st ave S Federal Way WA, 98003 by a representative of the Washington State Patrols, State Fire Marshal's Office, this complaint is in regards to a small fire in the commercial dryer on 8/20/2013.</p> <p>Findings (based on interview and review of a written report)</p> <p>On August 20, 2013 at 1:20 am a laundry worker put a load of laundry into the dryer, shortly after she smelled smoke; returning to the dryer she opened the door to see smoke inside the dryer and a small flame coming from under the drum, she then close the door to the dryer and removed other clothing items that were next to the machine and pulled the fire alarm she then waited for the fire department to arrive.</p> <p>The fire department arrived and put the fire out with a limited amount of water.</p> <p>There was no damage to the building and no staff or residents were injured.</p> <p>The facility has removed the dryer from use and will be replacing it soon.</p> <p>There is no further action required by the State Fire Marshal's Office.</p> <p> Deputy State Fire Marshal</p> | K 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.